alive. Median serum CRP values were 23.5 (0.2-122.6) mg/l and 3.72 (0.1-82.8) mg/l respectively (p=0.029). No correlation between CRP and pathologic stage of disease was found. Pretreatment Cyfra 21-1 exceeded 3.3 ng/ml in 6/9 pts who died and 7/30 pts who were alive. Median Cyfra 21-1 concentrations were 5.29 (2.5-14.5) ng/ml and 1.92 (0.7-6.2) respectively (p=0.0003). This difference was also significant if only stage I and II pts were taken into analysis.

Conclusion: Cyfra 21-1 and CRP are prognostic indicators in NSCLC patients treated by surgery and their influence on survival is probably partly independent from pathologic stage of disease.

P2-103 **BSTB: Prognostic Factors Posters, Tue, Sept 4**

Cytological Status of Pre- and Post-Operative Pleural Lavage and Lymph Node Recurrence in Patients with Early Stage Non-Small Cell Lung Cancer

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Background: Intraoperative pleural lavage cytology (PLC) in patients with early stage of non-small cell lung cancer (NSCLCs) has been considered as possible aids to assess prognosis of lung cancers and was reported to be useful in detecting sub-clinical pleural dissemination, local and systemic recurrence. Many studies revealed that only pre-operative PLC is necessary. We conduct a prospective study to explore any possible association of pre- and post-operative PCL and lymph node recurrence and the potential usefulness of post-operative PCL.

Methods: From December 2004 to December 2006, PLC was performed before and after any manipulation or resection of the lung in 24 consecutive patients, who had no macroscopic pleural effusion, dissemination, or diffuse adhesion, and who subsequently underwent curative resection for NSCLCs. The operations were performed by only one surgeon and the results of PLC with reference to clinicopathologic characteristics were evaluated and reported by only one pathologist. Tumor recurrence (local and systemic) was analyzed.

PLC consisted of cytological analysis of 50 mL of saline irrigated over the lung surface immediately after thoracotomy and after complete curative resection with radical mediastinal lymph node dissection.

Results: Nine (38%) of 24 patients had positive cytological findings. Positive cytological findings were observed more frequently in patients with adenocarcinoma, pleural involvement of the tumor and male gender.

Five (55%) of 9 patients had positive cytology in pre-operative PLC, 3 (33%) in post-operative and 1 (11%) in both pre- and post-operative PLC. Exact McNemar significance probability test showed no association between pre- and post-operative cytological status (p= 0.727).

The risk of lymph nodes recurrence after 3 month of curative surgery in patients with negative and positive pre-operative PLC was 5.6% and 33.33% respectively (risk ratio = 6, 95%CI = 2 to 8, p = 0.143). In patients with both negative pre- and post-operative cytology, negative pre-operative but positive post-operative, positive pre-operative but negative post-operative, and positive both pre-and post-operative were 6.7%, 0%, 20.0% and 100% respectively (p=0.123).

Conclusions: No relationship between cytological status of pleural lavage fluid pre-operatively and post-operatively was detected. The study showed that if malignant cells were found in pre-operative PLC, the risk of lymph node recurrence in 3 months increased by 6 times, and maximum risk occurred when the malignant cells was found in both pre- and post-operative PLC. However, the increased risk was not statistically significant because of the lack of statistical power due to small study size. If sample size were increased it may reveal that PLC may also be required at the time of curative resection for non-small cell lung cancer in order to estimate the risk of lymph node recurrence.

P2-104 **BSTB: Prognostic Factors Posters, Tue, Sept 4**

Role of ERCC1, XRCC3, Aurora A and TGFBR1 single nucleotide polymorphisms (SNP) and CHFR and 14-3-3 sigma methylation in a customized cisplatin (cis) trial based on ERCC1 mRNA levels in stage IV non-small-cell lung cancer (NSCLC) patients (p)

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Background: The primary aim of this trial was response. In both the control arm and in the genotypic arm with low tumor ERCC1 mRNA levels, p received docetaxel(doc)/cis; in the genotypic arm with high tumor ERCC1 mRNA levels, p received doc/gemcitabine. Response was significantly higher in the genotypic arms. We examined 324 p for genetic markers that could influence response, including ERCC1 118 C/T, ERCC1 C8092A, XRCC3 241 (Thr to Met), Aurora A 91 T>A, Aurora A 169G>A, a SNP within intron 7 of the TGFBR1 gene (Int7G24A), and an in-frame germline deletion (TGFBR1*6A). Methylation of 14-3-3 sigma and CHFR were also analyzed.

Methods: DNA from peripheral lymphocytes was used for genotyping (Taqman assay) and methylation-specific PCR was used for 14-3-3 sigma and CHFR in pretreatment serum DNA.

Results: There were no differences in clinical characteristics among the different SNP types, except that p with Aurora A 91 AA had higher tumor ERCC1 mRNA levels (P=0.005). No relationship was found between ERCC1 SNPs and tumor ERCC1 mRNA levels. A strong correlation was found between the Int7G24A and XRCC3 241 SNPs (P=0.03). The Int7G24A GA type had a higher odds ratio (OR) of response (OR 2.32) than the AA type (OR 3.15) (P=0.02). XRCC3 241 MetMet had a lower probability of response (OR 0.23) (P=0.04). No other differences in response were observed according to any of the other SNPs or methylation. In the multivariate model, the best response was observed in p with performance status (PS) 0, low ERCC1 levels, and XRCC3 241 SNP (Table).